



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

PREFERRED IMAGING AT THE MEDICAL
CENTER
5920 FOREST PARK ROAD
DALLAS TX 75235-6413

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4275-01

Respondent Name

W C SOLUTIONS

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our claim has been denied by the insurance carrier due to no pre-authorization. On 04/27/2011, we called and left a message with adj. Ms. Lori Hansen. She said since the compensability has not been determined service will be approved for reasonable and necessary. Therefore, the service was rendered. However, the insurance carrier has denied our claim due to no pre-authorization." "Our facility resubmitted the claim for reconsideration with supporting documentations. However, the carrier maintained their denial."

Amount in Dispute: \$692.21

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent maintains its original position as outlined in the EOBS as submitted by the Requestor." "The MRI was performed on 05/02/11, twelve (12) days post date of injury. Page 2 of Dr. Chavda's 04/26/11 office note stated 'NEUROLOGICAL: Grossly intact.' Page 3 reflects 'patient denied any loss of bladder or bowel control.' In addition, the injured worker had only four (4) days of physical therapy." Respondent asserts the service rendered required preauthorization, as the diagnostic/treatment is outside of or exceeded the ODG and did not meet the following criteria for MRI twelve days post date of injury: **Indications for Imaging – Magnetic resonance imaging:** * Thoracic spine trauma: with neurological deficit; *Lumbar Spine trauma; trauma, neurological deficit; * Lumbar Spine trauma: seat belt (change) fracture (if focal, radicular findings or other neurological deficit); *Uncomplicated low back pain, suspicion of cancer, infections, other 'red flags'; *Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; *Uncomplicated low back pain, prior lumbar surgery; *Uncomplicated low back pain, cauda equina syndrome; *Myelopathy (neurological deficit related to the spinal cord), traumatic; *Myelopathy, painful; *Myelopathy, sudden onset; * Myelopathy, stepwise progressive; *Myelopathy, slowly progressive; * Myelopathy, infectious disease patient; * Myelopathy, oncology patient. " "The requestor maintains its position that CPT code 72148 was correctly denied."

Response Submitted by: Edwards Claims Administration, 1004 Marble Heights Drive, Marble Falls, Texas 78654

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 2, 2011	72148	\$692.21	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out guidelines for preauthorization, concurrent review, and voluntary certification of health care.
3. 28 Texas Administrative Code §137.100 sets out guidelines for treatment in accordance with the current edition of the *Official Disability Guidelines – Treatment in Workers' Comp*.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 23, 2011

- 197 –Payment denied/reduced for absence of precertification/authorization.
- Comments: 197 –The treatment is outside of or exceeds the ODG, therefore, preauthorization is required.

Explanation of benefits dated June 26, 2011

- 197 –Payment denied/reduced for absence of precertification/authorization.
- 193 –Original payment decision is being maintained. This claim was processed properly the first time.
- Comments: 197 –Per rule 134.600 (p) (12), Non-emergency health care requiring preauthorization includes treatments and services that exceed or are not addressed by the commissioner's adopted treatment guidelines or protocols.
- Comments: The MRI criteria listed in ODG under 'Indications for imaging' were not met, therefore, preauthorization was required.

Issues

1. Did the treatment meet the criteria as set in the *Official Disability Guidelines – Treatment in Workers' Comp* in accordance with 28 Texas Administrative Code §137.100?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §137.100(f) states, 'a health care provider that proposes treatments and services which exceed, or are not included in the treatment guidelines may be required to obtain preauthorization in accordance with §134.600 of this title or may be required to submit a treatment plan in accordance with §137.100.' The criteria listed in the ODG treatment guidelines for low back injuries must meet all the requirements. If the requirements are not met, preauthorization is required. Review of the ODG treatment guidelines for diagnoses 722.10 – Lumbar Disc Displacement and 847.2 – Lumbar Sprain/Strain found that use of an MRI is not recommended.
2. Per Texas Labor Code, Section §413.011(b) "the insurance carrier is not liable for those specified treatment and services unless preauthorization is sought by the claimant or health care provider and either obtained from the insurance carrier or order by the commission." 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, "The carrier is liable for all reasonable and necessary medical costs relating to the health care required to treat a compensable injury...only when the following situations occur...preauthorization of any health care listed in subsection (p) of this section was approved prior to providing the health care." Review of the submitted documentation finds that the Requestor did not submit documentation to support preauthorization approval was obtained prior to providing the services in dispute in accordance with 28 TAC §134.600.
3. Review of the submitted documentation finds that the requestor did not meet the requirements of the *Official Disability Guidelines – Treatment in Workers' Comp* in accordance with 28 Texas Administrative Code §137.100 or seek preauthorization for the MRI in accordance with 28 Texas Administrative Code §134.600. Therefore, reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	October 27, 2011 Date
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YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.